



TRAVEL INSURANCE

Medical Expenses Claim Form

Thank you for notifying us of your claim.

Please complete **all** questions - if any question is not applicable please mark "N/A".

Please ensure that you sign the declaration on this claim form.

Name of Policyholder:	The University of Ghent
Policy No:	GBC9614 - Collective

Full Name of Insured Person: (Mr, Mrs, Miss, Ms)		Date of Birth:	
Full Address:			
Postcode:		City:	
Tel No. :		E-mailaddress:	

ACCIDENT/SICKNESS DETAILS

Please give the exact date and place when injured or taken ill:	Date:		Place:	
If accident , please state fully: (a) Where the accident occurred:				
(b) How the accident occurred:				
(c) The injuries sustained:				
(d) Name and address of any responsible person and his/her insurance company and policy number				
(e) Name and address of any witness(es) and/or authorities having made statements. If possible, report N°				

If illness , please state the full details of your illness:			
Please state whether you were in hospital:	YES/NO		
If YES, please state dates of Hospitalisation:	Admitted:		Discharged:
Have you previously claimed under this policy?	YES/NO		
If YES, please give details:			
Are you/the claimant covered under any group private medical scheme:	YES/NO		
If YES, please give name, address of the company concerned and the relevant policy/reference number:			
Please give the name and address and phonenumber of your attending General Practitioner.			

Details of expense - all accounts, bill, receipts, medical certificates, any correspondence and any other documents relative to this claim should be forwarded with this claim form. These must be the originals

Nature of Expense	Name and Address of Doctor or Hospital attended	Currency being claimed	Amount €	Paid (✓)
		Total €		

BANK DETAILS

When the claim has been approved the payment will be credited direct to your Bank Account. Please complete the following:

Name and address of your Bank:

Account n°:

IBAN:

SWIFT:

DECLARATION

I declare that all the information given is to the best of my knowledge and belief, full, true and correct.

Signed:

Date:

Failure to fully complete the form will result in a delay in handling your claim

Please return the completed claim form together with any enclosures to:

DE EUROPESE
Tweekerkenstraat 14
1000 Brussels
Phone: 02/220 34 11
E-mail: UGent@europese.be